New Horizons Counseling Services, Inc.

Demographic Form

NOTE: All information on this form relates to the identified client (the person receiving services). If you are bringing your child, please complete the form with the child's information.

TODAY'S DATE: _____

For the *person completing this form*, please provide the name/relationship to the identified client

NAME: _____ **Relationship:** _____

Legal Name: _____

First Last MI

Nickname: _____

Address: _____

Street Name & Number

_____

City State Zip

Phone #: _____

Primary# Cell Home Work **Secondary #** Cell Home Work

Email: _____

NHCS, Inc respects your privacy and will only contact you with general information, such as appointment reminders and invoices that you would be expecting.

You may leave general messages on my phone: ☐ Yes ☐ No

You may send me emails/text messages: ☐ Yes ☐ No

Date of Birth: ____/____/____ **Social Security No**. ____-____-____

Age: _____

Gender: _____ **Marital Status:** _____

Ethnicity: _____ **Primary Language:** _____

EMERGENCY CONTACT INFORMATION

Name: _____

First Last Relationship to Client

Phone #: _____

Primary# Cell Home Work **Secondary #** Cell Home Work

Insurance Information

I have provided a copy of my most recent insurance card to the front desk. ☐ Yes ☐ No

If no, please explain_____

I understand that I am required to pay at the time of service and will be billed for any balance. NHCS, Inc can take check, cash, or credit card payments as well as funds from health savings accounts.

NHCS, Inc wants to work with each client to help provide affordable services; pleases help us by providing your most recent insurance information and speak with us regarding any changes.

Insurance Company _____

FOR PSYCHOTHERAPIST ONLY DX:_____

NAME:_____

Educational and Work History

EDUCATION:

Highest Grade Completed in school: _____

Any behavioral Problems _____

Any Academic Problems _____

_____

Name of your School District: _____

Name of your School: _____

Guidance Counselor Name/Contact Person: _____

EMPLOYMENT:

What is your Occupation? _____

Name of your Employer: _____

Do you enjoy your job? _____

What are your concerns at work? _____

_____

Family Doctor

Practice Name: _____

Doctor Name (if preferred): _____

Address: _____

Phone Number: _____

Please provide pharmacy if attending psychiatric services

Pharmacy Name: _____

Address: _____

Phone Number: _____

A release will be signed in order to communicate with any person(s) or agencies listed.

Agency	**n/a**	Contact Person(s)	Contact Number
Lancaster County BHDS			
Children and Youth			
Probation or Parole			
Intermediate Unit (IU13)			
Adoption or Foster Care Agency			
Options/Goodwill/Concepts			
Office of Aging			
Victim Witness Services			
Department of Public Welfare			
Attorney			
Guardian At Litem			
Other:_____			
Other:_____			

*** If you do not have any of these services, please mark **n/a** for not applicable.***

NAME:_____

Mental Health History

Please be open about your thoughts and feelings, you are the owner of your story. A clinician can only help as much as you allow. The more detail you provide the better we can individualize our work together.

*****(Please answer the questions in regards to the person identified as the recipient of counseling.)*****

How were you referred to Counseling? _____

Please describe if this was **not a self referral**:_____

_____

Have you ever sought counseling or any other mental health services in the past? ☐ Yes ☐ No

If yes, please describe the reasons you sought counseling?_____

_____

_____

Have there been any hospitalizations due to mental health issues? ☐ Yes ☐ No

If yes, please describe this to the best of your ability, when and where, for how long:

_____

_____

Where you ever diagnosed with a mental health condition? ☐ Yes ☐ No If "yes", please list:

_____ _____

_____ _____

Each person has a story related to difficulties in life. A trauma is not defined by anyone else but the person who has experienced the traumatic event. These can range from abuse to repeated losses in your life.

Has there ever been a traumatic experience in your life? Explain:_____

_____

_____

What are your concerns right now? _____

_____

_____

How long has this been an issue?

_____

How often does this occur? (Time of day, frequency, duration)

_____

Are there any situations or circumstances that trigger your concerns? Explain:

_____

_____

Where do these issues occur (home, school, office, etc.)?_____

_____

When becoming upset or these problems occur, how do you respond?_____

_____

****Many individuals have had suicidal ideations, which does not necessarily reflect a desire to die, but can often mean that a person is overwhelmed with a situation in life and just wants that to end.****

Have you ever had thoughts of **suicide**? **YES** **NO** When? _____ Currently? _____

If yes, please describe?_____

Have you ever had thoughts of **hurting yourself**? **YES** **NO** When? _____ Currently? _____

If yes, please describe?_____

Have you ever had thoughts of **hurting another person**? **YES** **NO** When? _____ Currently?_____

If yes, please describe?_____

Suicide Prevention Lifeline (800) 273-8255 **For psychotherapist only:** Initials:_____

NAME:_____

Each person enters mental health care because of a situation or need.
This situation or need does not define a person, it merely encourages you to seek help.
Building upon skills and other strengths you have will be important to the therapeutic process.

Describe a good day for you? _____

_____

What activities do you enjoy and/or how do you relax (i.e. hobbies, watching movies, gardening, yoga)?

_____

_____

What are your Strengths? _____

_____

List community programs in which you participate: (e.g. church, sports, support groups)

_____

_____

Who provides support for you?

NAME:	Relationship	How do you contact them? Phone number, Facebook, See him/her at church

Therapist Comments: _____

_____

_____

_____

_____

Medical History:

Any other medical issues? ☐ Yes ☐ No

Medical Issue	EXPLAIN (When did it begin, how is being treated and by whom)

Has there ever been **Medication** prescribed to treat any **MEDICAL/BEHAVIORAL** concerns? ☐ Yes ☐ No

Explain: _____

List any Current and Past Medications:

Name of Medication	Prescriber	Reason Given	Dose and frequency	Current	Past

NAME:_____

SELF

Mental Health	**Yes**	**No**	**Explain**
Alcohol Use*			
Drug Use* 800-662-4357 (apps.ddap.pa.org)			
Tobacco Use* 800-784-8669 (smokefree.org)			
Criminal Activity			
Domestic Violence 717-299-1249			
Physical Abuse			
Sexual Abuse 717-392-7273			
Neglect			

Physical Health	**Yes**	**No**	**Explain**
Allergies			
Surgeries			
Head Injuries			
Seizures / Epilepsy			
Loss of Consciousness			
Thyroid			
Cancer			
STD's 919-361-8488 (thestdproject.com)			
Heart Disease			
Diabetes			
High Blood Pressure			
Other:_____			
Other:_____			
Other:_____			

*****Further information is available to assist in discontinuation of substance use*****

The numbers provided have been called and someone does answer. They will take the time you need to help you with your concerns. *Please remember to reach out, someone will reach back.*

Please describe your alcohol use (e.g. 1 or 2 a month, socially, every weekend…)?

_____

Please list any drug use (This is only to provide a thorough history so that we are aware of any circumstances that can contribute to your current physical and mental health state)

Drug Name	N/A	How Often?	Current	Past	Therapist Comments:
Marijuana					
Cocaine					
Heroin					
Opiates					
Amphetamines					
Methamphetamines					
Ketamine					
Steroids					
Benzos (Ativan, Xanax)					
Hallucinogens					

NAME:_____

Checklist of Concerns

Please mark all of the items below that apply:

❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
❑ Aggression, violence
❑ Alcohol use
❑ Anger, hostility, arguing, irritability
❑ Anxiety, nervousness
❑ Attention, concentration, distractibility
❑ Career concerns, goals, and choices
❑ Childhood issues (your own childhood)
❑ Codependence
❑ Confusion
❑ Compulsions
❑ Custody of children
❑ Decision making, indecision, mixed feelings, putting off decisions
❑ Delusions (false ideas)
❑ Dependence
❑ Depression, low mood, sadness, crying
❑ Divorce, separation
❑ Drug use—prescription medications, over-the-counter medications, street drugs
❑ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
❑ Emptiness
❑ Failure
❑ Fatigue, tiredness, low energy
❑ Fears, phobias
❑ Financial or money troubles, debt, impulsive spending, low income
❑ Friendships
❑ Gambling
❑ Grieving, mourning, deaths, losses, divorce
❑ Guilt
❑ Headaches, other kinds of pains
❑ Health, illness, medical concerns, physical problems
❑ Housework/chores—quality, schedules, sharing duties
❑ Inferiority feelings
❑ Interpersonal conflicts
❑ Impulsiveness, loss of control, outbursts
❑ Irresponsibility
❑ Judgment problems, risk taking
❑ Legal matters, charges, suits
❑ Loneliness
❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
❑ Memory problems
❑ Menstrual problems, PMS, menopause
❑ Mood swings
❑ Motivation, laziness
❑ Nervousness, tension
❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
❑ Oversensitivity to rejection
❑ Pain, chronic
❑ Panic or anxiety attacks
❑ Parenting, child management, single parenthood
❑ Perfectionism
❑ Pessimism
❑ Procrastination, work inhibitions, laziness
❑ Relationship problems (with friends, with relatives, or at work)
❑ School problems (see also "Career concerns ...")
❑ Self-centeredness
❑ Self-esteem
❑ Self-neglect, poor self-care
❑ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
❑ Shyness, oversensitivity to criticism
❑ Sleep problems—too much, too little, insomnia, nightmares
❑ Smoking and tobacco use
❑ Spiritual, religious, moral, ethical issues
❑ Stress, relaxation, stress management, stress disorders, tension
❑ Suspiciousness, distrust
❑ Suicidal thoughts
❑ Temper problems, self-control, low frustration tolerance
❑ Thought disorganization and confusion
❑ Threats, violence
❑ Weight and diet issues
❑ Withdrawal, isolating
❑ Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition

Additional Information:

_____
_____
_____
_____

NAME:_____

Please complete household member's table and the following family medical history with information related to the recipient of counseling (Identified Client)

Members of the identified client's household: ☐ **N/A single person household** **HOUSEHOLD**

Person's Name	Age	Relationship to client	***Mother/Father

Parents Living in Separate Households? ☐ Yes ☐ No If **yes**, please indicate which **household*****

NOTE: Both households are important to a child, please include both. Add more on the back, if necessary

Family Medical History

Family: ☐Biological or ☐Adopted

Mental Health	**Yes**	**No**	**Explain** (Family Member, Mother/Father's side, Specific Issue, Other Information)
Alcohol Use*			
Drug Use* 800-662-4357 (apps.ddap.pa.org)			
Tobacco Use* 800-784-8669 (smokefree.org)			
Criminal Activity			
Domestic Violence 800-799-7233 (thehotline.org)			
Physical Abuse			
Sexual Abuse			
Neglect			
Physical Health	**Yes**	**No**	**Explain**
Allergies			
Surgeries			
Head Injuries			
Seizures / Epilepsy			
Loss of Consciousness			
Thyroid			
Cancer			
STD's 919-361-8488 (thestdproject.com)			
Heart Disease			
Diabetes			
High Blood Pressure			
Other:_____			
Other:_____			
Other:_____			

NAME:_____

Developmental History

** If the client is over 18 years of age, Skip Developmental section*

******Unless you think it is significant******

Sometimes people have significant developmental history, like being premature, please include that even if you are an adult. Those developmental aspect of your life are important even now.

Developmental History	*AGE it Occurred*	*Explain any Delays*
Crawled		
Walked		
Toilet Trained		
Spoke		

Describe any current developmental delays? _____

_____

_____

Describe the child's current social skills? _____

_____

_____

Therapist Comments: _____

_____

_____

**** If the client is over 18 years of age, Skip Legal Custody or it does not pertain to the client.****

Legal custody

What is your relationship to the child?	Adoptive parent - Foster Parent - Legal Guardian
If none of the above Explain	
Who has Legal Rights?	
Who has Physical Rights? Custody?	
If applicable, who is the Guardian Ad Litem?	

Is there anyone else who *legally* has rights to the medical information regarding this child?

Name: _____

First Last Relationship to Client

Address: _____

Street Name & Number

_____

City State Zip

Phone #: _____

Primary# Cell Home Work **Secondary #** Cell Home Work